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Raffaella Ferrero Camoletto, Department of Cultures, Politics and Society, University of Turin

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Abstract

The advent of Viagra and its competitors has triggered a proliferation of discourses on male sexual lifestyles and life courses and endorsed their adjustment through medical treatments and pharmaceutical devices. This chapter explores how Italian general practitioners position themselves within this scenario, showing how GPs, while accounting for their male patients' sexual health problems, tackle the process of sexual ageing. In their narratives, GPs embody, convey, and sometimes question the socially available representations and cultural norms defining what sexual ageing is or should be.

Introduction

Since the beginning of the 21st Century, insistent social campaigns – partly due to the banning of direct-to-consumer advertising of prescription drugs in Europe – have been "problematizing" dimensions of male sexual lifestyles and life courses and endorsing their adjustment through medical treatments and pharmaceutical devices. These social campaigns, promoted by professional associations of physicians (urologists, andrologists, sexologists, etc.) and supported, in most cases, by both institutional bodies (including the Ministry of Health) and pharmaceutical companies, are aimed at informing the general population about diverse male sexual dysfunctions and at promoting the available medical treatments available. In so doing, they contribute to the notion that male sexual health is a new public issue, and thereby to constructing both a masculinity that needs to be "fixed" and to new forms of medical expertise legitimized to treat it (for a previous analysis of these campaigns, see 13).

This chapter explores how Italian general practitioners position themselves within this proliferation of expert discourses on sexual medicine: more specifically, it investigates how GPs, while accounting for their male patients' sexual health problems, tackle the process of sexual ageing. We show how medical discourses embody, convey, and sometimes question the socially available representations and cultural norms defining what sexual ageing is or should be. A key component of this cultural scenario in which medical experts are embedded is the advent of sexuo-pharmaceuticals like Viagra and its competitors, hand-in-hand with another contemporary feature, the expanding rhetoric of "positive ageing," in its various permutations ("active ageing", "successful ageing", "healthy ageing", etc.). At the crossroads of these two cultural phenomena we witness a transformation of the way people, especially men, perceive and experience age-related sexual changes, with a relevant shift from a notion of old age as characterized by a process of de-sexualisation and of "sexual retirement" to a new representation of ageing people as "sexy oldies" (20) or "sexy seniors" (44).

This cultural revolution of a re-sexualization of later life challenges well-established medical – as well as commonsense – understandings of sexual ageing, compelling medical experts to face an open battleground of different perceptions and definitions of what is normal in sexual ageing.

Previous research (2, 3, 20, 60) has pointed out the difficulties general practitioners face when dealing with sexual issues, especially with midlife and older patients.

Relying on data from a recent mixed-method qualitative research project carried out in Italy, we analyze how GPs both adopt and question socially-available scripts of ageing, gender, and sexuality. In their clinical practice, GPs tend to overlap the natural, the normal, and the normative (27) by medically reframing as "sexual health" what they perceive as an age-appropriate "respectable sexuality" (4, 66) for ageing men and women.

1. Beyond sexual retirement: the impact of positive ageing and the Viagra revolution

Gerontologists have criticized the notion of "successful" and "active" ageing because of their neoliberal focus on productivity and their consumeristic anti-ageing approach, both of which restrict the understanding of the ageing process (5, 7, 30, 48, 57). Successful ageing seems to have become one of the contemporary obsessions (33), focussing on individual agency and choice to maintain "busy bodies" (29) and to withstand the cultural markers of old age (21, 30, 31). As Twigg and Martin (63, p.355) pointed out, this opens up "new territory for empirical investigation in which the body is understood as a key site for the operation of new forms of governmentality. … The bodies of older people are disciplined and made subject to regimes of fitness and health in which responsibility for ageing well becomes a moral imperative".

Within this frame, a "lifelong sexual function" (46) becomes a primary component of healthy and successful ageing, imposing the new imperative of "sex for life" (32), envisaging a "virility surveillance" (44) by which "the floppy penis" (9) in ageing men is seen as a warning signal of a precariously abnormal condition, current or future, requiring medically-assisted restoration (34, 43).

The so-called "Viagra studies" have emerged as one of the research streams investigating men's ageing and sexuality within a medicalized frame (23-25, 28, 36, 38-42, 45, 52, 53, 58-62, 65-67). Thus, the advent of Viagra has triggered a radical transformation in the perception of age-related changes in male sexuality.

In their reconstruction of the previous Western cultural scenario, Potts et al. (53) pointed out how in the pre-Viagra era the prevailing narrative about male ageing was the notion of an inevitable sexual decline, associated with a physiological reduction of erectile ability. Other narratives were available, but less used and less acknowledged, for example, the so-called "progressive narrative," interpreting the effects of decreased erectile ability as an opportunity to live a sexuality less centered on penetrative potency, but open to the experimentation of different sources and forms of sex. In the Viagra era, both these narratives have been replaced by that of the "sexy oldie," connecting healthy ageing with lifelong sexual activity following a "forever functional" imperative (46). Progress then has been re-interpreted in terms of a restoration of youthful sexual skills and of the enhancement of never-attained sexual performances, constructing a new pharmacologically-assisted virility (40, 44) and a "cyborg masculinity" (51).

Research on ageing men has outlined, however, the persistence of the narrative of decline. For instance, a study of Mexican men (66, see also Chapter 2) showed how ED medicines can endanger men's notion of a respectable sexuality and of a mature and responsible masculinity. Sexual difficulties can therefore be redefined as natural sexual changes, rejecting the pathologizing label of sexual dysfunction and the risk of "getting viagraed" by an artificially produced pharma-mediated sexuality (67). The research literature has also noted that some ageing men may adopt the narrative of progress (53, 66) as an alternative understanding of sexual ageing: for instance, in her analysis of older Swedish people's accounts, Sandberg (58, 59) introduced the notion of an "intimacy narrative" to frame how her interviewees tended to interpret life-course-related sexual changes as an opportunity to experience different, richer forms of sexual expression.

2. Medical experts facing sexual issues: a review

While providing a multifaceted picture of patients and consumers, Viagra studies often assign to medical experts the role of transmission chains of a top-down process of medicalization of sexuality. In fact, few studies have investigated how physicians – either as sexual medicine professionals or as general practitioners – culturally define, and accordingly treat, life-course-related sexual changes. In what is depicted as medical experts' compliance with the new engine of "pharmaceuticalization," the possibility of their reflexivity and resistance seems to have been overlooked[i].

A review of the literature provides a picture of scattered, mainly quantitative, research on this topic. In Europe[ii], the most investigated national case is the UK (17-20, 26), while other national contexts are only partly covered: France (16), Ireland (8), Portugal (1, 54, 55), and Switzerland (49, 50). These studies outline different barriers to raising the subject of sex among both GPs and their (older and not-so-old) patients.

Physicians, on the one hand, describe their own difficulties in addressing sexual issues. The most common justification is the lack of time in everyday clinical practice (e.g. 55); however, this perception of a time-constraint can be influenced by the cultural belief that sexual health is not a priority issue when dealing with older patients, therefore endorsing commonsensical notions of an asexual old age (1, 19). Another relevant, recurring barrier is GPs' admission of, and complaints about, a lack of training and education in their academic curricula on such a sensitive topic. For instance, in British qualitative studies, physicians describe their fear and discomfort in initiating a dialogue on sexual issues by adopting catchphrases like "opening a can of worms" (18) or "opening a floodgate" (26).

Because of this combination of lack of time and lack of training, GPs often seem to consider sexual health as an inappropriate and non-legitimate topic to be proactively introduced into their professional interaction with older patients. As a consequence, many physicians adopt a reactive style, limiting themselves to responding to sexual concerns and problems brought to them by patients. However, some GPs acknowledge the importance of their role as gatekeepers of the definitions of healthy ageing and therefore in their "permission granting role" of legitimizing normal and appropriate age-related sexualities (20).

Giami (16), in his qualitative study on French GPs, provides a useful typological summary of approaches to sexual issues. The first approach is "evasion" (*évitement*), involving selective exclusion of, and resistance to, tackling sexual issues due to the above-mentioned excuses such as lack of time and pressure from other clinical priorities; irrelevance of the topic for older patients; and fear of violation of patients' privacy and intimacy. The second approach is called "medical re-appropriation," when the GP adopts a relative, partial avoidance by reframing sexual problems as a matter of physiology, infections, contraception, etc., and therefore acknowledging them as legitimate medical problems. The third approach is called "holistic" because it makes reference to GPs' adoption of a more comprehensive understanding of health issues, including sexual issues as a key dimension of well-being. The fourth approach is the quest for some sort of sexological specialization pointing out the importance of specialized training in sexual medicine for GPs' academic curricula and clinical practice.

In this fragmented review of the literature, Italy appears to be lagging behind: among the studies addressing Italian general practitioners' attitudes and behavior within their medical profession, the style of management of sexual health issues seems to be a neglected theme (for an exception among clinical studies, see 10). This shortfall in research points to the need for exploring the complexity of GPs' accounts of their experience in dealing with their older patients' sexualities.

3. Current study: context and methodology

In this chapter, we draw upon empirical material collected within a current multi-method qualitative follow-up research project (started in 2016) on the transformation of representations and experiences of ageing and sexuality in Italy. Previous research (see 13-15) carried out in Italy from 2010 to 2015 focussed on social awareness campaigns about male sexual health. These campaigns aimed to inform the general population about the diversity of men's sexual problems and to promote obtaining medical advice, thereby constructing a definition of the problem to be solved, the patients to be cured, and the strategies for resolution, including treatments to be adopted. This research project included a thematic analysis of visual and textual documentary material produced by major national awareness campaigns on male sexual health websites and videos ("Amare senza pensieri", 2008-09; "Amico andrologo", since 2009; "Basta scuse", 2010; "Chiedi aiuto", 2012; "Uomo e salute", 2013); websites on male sexual health managed by medical experts (www.pianetauomo.eu, promoted by SIU, the Italian Urological Society; www.prevenzioneandrologica.it, promoted by SIA, the Italian Andrological Society); and by pharmaceutical companies (www.lillyuroandrologia.it, promoted by Lilly). Nineteen interviews were carried out, along with one round table of experts in the field of sexual medicine (urologists, endocrinologists, sexologists, sex counsellors), recruited because of their involvement in these campaigns[iii]. In addition, interviews with two groups of product-development and marketing managers from two major pharmaceutical companies' Italian subsidiaries (Lilly and Menarini) were conducted.

The project narrowed the field of investigation by focussing on the impact of the Viagra revolution and of the rhetoric of active ageing on the representations and experiences of sexual ageing and on the controversial notion of ageless sex. The project involved an analysis of media and medical documents on older people's sexual health; interviews with GPs (in progress, no.23), and focus groups and interviews with older people (in progress, respectively no. 4 and no.7) in order to explore their perceptions and experiences of sexual ageing.

In this chapter, we focus on the in-depth interviews with general practitioners. The interviews, lasting from 30-40 to 90 minutes, have been fully transcribed and submitted to open, axial coding procedures with Atlas.ti software. Following a thematic analysis (6), we have reconstructed how doctors debate the issue of sexual ageing. To summarize how GPs differ in their views of older people's sexual health, we combined the two typologies of the above-mentioned qualitative studies (19 for the UK, 16 for France), identifying five styles of sexual health management: (a) *reactive evasion*, when sexual issues are not seen as a priority or are considered a risky topic to be dealt with only when patients introduce it; (b) *reactive sexological specialization (*or *delegation)*, when sexual issues are delegated to sexual-medicine experts; (c) *proactive medical appropriation*, when sexual problems are reframed as medical problems relating to physiology, infections, contraception, etc.; (d) *proactive holistic approach*, when sexual issues are framed within a more general view of well-being; and (e) *proactive sexological specialization*, when GP's training in sexual issues is demanded.

In the following section, some of the preliminary results are presented and discussed.

4. "Letting sleeping dogs lie": between avoidance and delegation.

In Italy, similarly to what has been outlined in the above-mentioned research into other national contexts, GPs do not appear at ease in dealing with sexual issues in their everyday interactions with older people: sexuality is perceived as a buck to be passed on as often as possible, and to be managed cautiously when unavoidable. Talking about sex, therefore, seems to be legitimate only if patients introduce the topic. GPs fear being accused of invading patients' private spheres, and of their patients' unpredictable reactions when such a sensitive topic is mentioned.

It means being available to help them in relation to this issue … if they mention it ... If they don't say anything, it's a bit more difficult for me to initiate the conversation about it because I don't know how the patient will react (GP, female, 60).

These are niche topics, speaking about male patients, since women absolutely don't talk about them because for women to stop having sex after the menopause is perfectly normal. For a man the problem is still present at an older age, but in my experience it is an issue I rarely deal with because I let sleeping dogs lie (GP, male, 52).

Not only are sexual issues perceived as a sensitive, private matter, but some physicians refer to sexuality as an inappropriate topic beyond medical jurisdiction: talking about sex appears to be a more mundane practice to be dealt with in a confessional by a spiritual guide, or within psychological counselling requiring a different kind of professional training and environment. *Some patients reacted with "Mind your own business!", as if they didn't consider this query of professional interest, as if this issue were detached from general health … as if it should not be investigated by someone wearing scrubs, but rather by someone wearing a cassock or a psychiatrist (GP, male, 51).*

Some GPs, on the contrary, acknowledge the relevance of sexual health and the importance of managing sexual problems, but they tend to delegate this task to specialists in sexual medicine. *If a patient introduces the problem, I take it into account, I give the appropriate therapeutic indications … I always do a checkup, then I send him/her to a specialist … [Sexual issues] are very often related to other pathologies … they are delegated to urologists or gynaecologists (GP, female, 51).*

The risk in this approach seems to be that of reducing the GP's role to sorting patients or, as is often admitted, to solving sexual problems mainly or only by prescribing pharmaceuticals. *It is a niche issue, not so often dealt with in general practice. I personally don't encourage the patients very much, that's true, but it's very rare for a patient to talk to me about sexual problems, or if he does it's because he knows there is a little pill, a little help requiring medical prescription, so in the end [my role] comes down to prescribing these drugs (GP, male, 52).*

5. Proactive approaches: sexual issues as a door-opener to the patient's healthy life

In this next section we see how, for some GPs, managing their older patients' sexual impairment is not only perceived as legitimate clinical practice, but also as an opportunity to build stronger therapeutic compliance. Thus, some GPs claim a more proactive role. This can mean a medical re-appropriation of the investigation of sexual issues, as in this long quotation from a GP for whom managing patients' sexual difficulties emerges as the most satisfying part of his job for two reasons: because it makes the patients happy and meets their real needs, and because it triggers a stronger doctor/patient relationship, empowering therapeutic alliance and reinforcing GPs' professional status. *The best part of my work is the rare occasions when you have direct contact. When the patient comes, takes a seat, opens up, says: "Listen, doctor, I have a problem, things are not going well with my wife". He approaches it indirectly. So you ask: "What do you mean?" "Well, it isn't working properly". So you start to put your heads together, you explain which drugs are available, how they work, how to use them, you crack some jokes … It's different from prescribing antibiotics against bronchitis; maybe it works but the following week the patient doesn't come to say "Thanks". The patient with erectile deficit, if the treatment is successful, comes back with a smile from ear to ear (GP, male, 45).*

The specificity of sexual issues within this approach is re-interpreted positively: no longer perceived as an inconvenient, delicate topic, it acquires the role of door-opener to gain the patient's trust. Moreover, for a few GPs a proactive style of medical management also conveys a more comprehensive and holistic notion of health, including sexual issues as a core dimension:

talking about sex is part of an "all-embracing" view of the patient's well-being. *Well, if we want to take into account the individual's well-being, we must necessarily manage it [sexual health] too … Well-being is a completion of physical, psychological and – why not? – sexual dimensions. Therefore it is all-embracing, it is present in all our medical investigations (GP, female, 56).*

Within this perspective, GPs tend to consider sexual problems as an important sentinel and as predictors of a wider range of dysfunctions and pathologies, and therefore requiring careful, committed medical attention. The acknowledgment of sexual health as a legitimate topic for GPs leads some to admit their lack of an appropriate academic background and to ask for specific training in sexual medicine as a useful tool to deal better with their patients and solve their problems. *In my opinion, it [talking about sex] should be part of our … like when we ask "Does it hurt when you urinate? What does it smell like?" … We should remember to ask it … But first of all, we need scientific evidence … because I wasn't specifically trained for that. So, if we had had specific training, we could intervene more appropriately on certain problems, replacing the smile on our patients' faces. (GP, male, 45)*

6. Debating the sexy oldie's health

In addition to the distinction between reactive and proactive approaches, GPs' narratives reveal some ambivalence about the definition of sexual ageing and what is natural or normal in later-life sexuality. As pointed out in Section 1, medical discourses are enmeshed with cultural beliefs, values, and representations of gender, ageing and sexualities. The diverse styles of medical management of old people's sexual health problems also channel and express different ways of defining and understanding what is appropriate in sexual ageing. Some GPs seem to introduce a normative dimension into their clinical approach, conveying the new "must" of lifelong active sexuality (46): older people are expected to continue an active sexual life as part of a healthy lifestyle. Therefore GPs "willingly" handle the request in order to support their patients' sexual "rebirth" and a lifestyle of "being fully aware of your body". *It is clear that at 70 you cannot perform as you could at 30, but you can (and should) have an active physical – including sexual – life, naturally using different ways and means … People at 65-70 have no sexual life, and I, in my 50s, think this is sad and tragic (GP, female, 51). Let's open GPs' minds to sexuality, please! Because sometimes they are more bigoted than their patients … The aim is to make patients more alive, respecting and promoting sexual activity as producing beneficial effects … What could be better than living healthily, with this lifestyle, being fully aware of your body (GP, female, 56).*

In opposition to this enthusiastic view of later sexuality as a rebirth and re-appropriation of an active sexual lifestyle, other GPs outspokenly make reference to an overlapping of natural/biological and social/moral standards in defining age-appropriate sexual conduct (47). *To increase your performance is a current pipe dream, not only in sex … But I believe, not only as a GP but also personally, that you pay for this. If you go against nature, against the opportunities nature provides, you can end up not being able to use what your age allows. I have some cases in mind ... Patients who resist my attempts to discourage them from seeking from drugs what nature hasn't given them. And they have lives which are ridiculous in my opinion ... What makes me laugh is that they believe they are successful because they perform extraordinarily well. The only evidence is that they have extraordinary brains [laughing], small ones (GP, male, 51).*

The quest for a pharmacologically assisted everlasting sexuality is re-interpreted as a consumeristic approach and as an artificial way of coping with the naturalness and inevitability of the ageing process. Moreover, this obsession with sexual rejuvenation exposes patients to the risk of looking ridiculous and paying the price. However, in a few GPs' narratives we find some room for the acknowledgment of a wider range of options of age-related sexual expressions, providing, especially for men, the possibility of moving beyond the sex-machine script. In the following

quotation we see a GP legitimizing different ways of managing sexual ageing: a midlife man who is seeking to ensure his own and his partner's wider well-being, as well as an older man admitting that he is no longer interested in sex after losing his wife. The point is everyone has the right to an appropriate healthy and pleasant sexual life at any stage of the life course, being aware of the different bodily options and pleasure available at different ages.

It reminds me of a patient I had a few years ago, who told me: "You know, I have a new partner and I want to make her feel well, to feel well myself too, therefore … do you think I should do something about it?". I think this is very healthy and positive … Last week a 78-year-old patient told me: "Listen, since my wife [with whom he had lived for 50 years] died last year, I don't desire other women, I don't feel like it", and I replied "I think it's physiological, because you are 80 and you have always lived with your wife", with whom he had an active sexual life. It's absolutely normal … There should be more publicity about the right of a man, even at 70, to have a pleasant sexual life; about the right of a woman, at 15, 60, 70, 103, to have a pleasant sexual life, using different ways and means, which is evidently physiological. At 60 you don't run a marathon, you do a little jogging (GP, female, 55).

The reference to a context-dependent understanding of ageing and sexuality seems to create some room to question a reductionist naturalized notion of sexual functioning in order to recognize the influence of social and cultural dimensions shaping how older people make sense of their sexualities across their life course. However, as discussed in the last section, GPs' accounts more frequently tend to endorse a "healthicization" of sexuality (11) which, in defining what is a healthy sexual lifestyle in later life, merges the natural, the normal, and the normative.

Conclusion and implications

In this chapter we have explored the variegated impact of active ageing and ageless pharma-mediated sex discourses in GPs' narratives. In the background, we find some evidence of a process of normalization of ageing through a moralization of (sexual) health (27), a process to be inscribed within a neoliberal notion of good bio-citizens responsible for their bodily maintenance (56).

In GPs' narratives, we can detect an overlapping in the definition of what is physiologically, statistically and socially normal. The boundaries of age-appropriate sexual health seem to be traced back to the gendered script of a "respectable sexuality" (4, 66): men are expected to walk on the razor's edge of keeping sexually active without becoming "dirty old men" or "sugar-daddies" (64), while women have to find a balance between maintaining sexual desire and attractiveness and avoiding being labelled as cougars or mutton dressed as lamb (12).

GPs can therefore risk affirming or reinforcing a (new?) normative model of a forever-functional sexuality, perceived as a right but also as a duty for older people (Marshall 2012). As we have seen, Viagra fostered a new ageless virility in which maintaining sexual potency, measured as penetrative capacity, is a signal of good health and of positive/active/successful ageing. However, medical accounts have exposed a tension between the two positions: on the one hand, the acknowledgment of new generations of sexy seniors' right and expectation to maintain a satisfying level of sexual activity, thanks to pharmacological and mechanical devices; and on the other hand, the rejection of a consumeristic approach to sex and the claim to restore the social role of physicians as gatekeepers of sexual health and of respectable sexual ageing. General practitioners' accounts, in their ambivalent definition of the "functional age" at the intersection of biological and biographical trajectories, are emblematic of the "contradictions of 'post-ageist' discourses and practices that promise to liberate bodies from chronological age, while simultaneously re-naturalizing gender in sexed bodies" (47, p.222).

GPs could also work at dismantling some of the stereotypes and prejudices about older people's sexuality: more specifically, they could endorse what Gott (20) called a "permission-

granting role," extending the definitions of normal and appropriate ageing sexualities. In some GPs' accounts we have found clues as to how to make room for a progressive narrative, acknowledging a wider range of age-related sexual expressions (53, 59), thereby giving legitimacy, for both men and women, to diverse ways of coming to terms with the sexual changes occurring across their life course.

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[i] For an investigation and introduction to a social debate on this issue in the Italian context, see 13-15.

[ii] On Malaysia for an interesting study adopting focus groups to explore GPs’ attitudes towards sexual health outside Europe, see 37.

[iii] The key limitation of the study depends on the small scale of the sample, restricting the possibility of taking into account the influence of some structural dimensions, mainly gender and age cohorts of the medical experts interviewed.